SUPPLEMENT A

MEDALLION

SUPPLEMENT A
TABLE OF CONTENTS

SUPPLEMENT A
MEDALLION

SECTION I
INTRODUCTION

This supplement to the DMAS provider manuals explains MEDALLION and its policies and procedures. The intent of the supplement is to provide both MEDALLION Primary Care Providers (PCPs) and other Medicaid providers with the necessary information to provide services and receive reimbursement for them.

SECTION II
GENERAL INFORMATION

Virginia requested and received approval from the Health Care Financing Administration (HCFA) for a waiver under § 1915(b) of the Social Security Act. Under this waiver, Virginia will provide coordinated care services to selected Medicaid recipients in the Commonwealth.

The services provided by this waiver establish and support Primary Care Providers (PCPs) who become care managers responsible for the coordination of MEDALLION recipients' (hereafter referred to as "recipients") overall health care. The PCP assists the recipient with gaining access to the health care system and monitors on an ongoing basis the recipient's condition, health care needs, and service delivery, including referrals to specialty areas. The intent of this form of health care delivery is to foster a more productive physician/patient relationship, to reduce the inappropriate use of medical services, and to increase recipient knowledge and use of preventive care.

The *Options* voluntary HMO program is available for MEDALLION recipients in cities and counties throughout the Commonwealth. All managed care-eligible recipients participating in *Options* have the opportunity to select an HMO for their Medicaid health coverage. In many other localities in the Commonwealth, a mandatory HMO program, Medallion II, is required for most Medicaid recipients. In order to participate in the *Options* and Medallion II programs and, thus continue to care for Medicaid recipients assigned to these programs, the Medicaid provider must also contract with the Medicaid HMO in the locality. For more information on both of these HMO programs, refer to Chapter I of this manual.

DMAS is the single state agency responsible for the administration of MEDALLION. DMAS contracts with the providers of services who meet all licensing and certification criteria stipulated in this supplement and who are willing to adhere to DMAS policies and procedures. See “Exhibits” at the end of this supplement for a sample provider Participation Agreement and MEDALLION Provider Enrollment Form.

SECTION III
PROVIDER PARTICIPATION REQUIREMENTS

Physicians who wish to enroll as PCPs in MEDALLION must contact the DMAS contractor that coordinates physician enrollment to request an application and other practitioner information and documents. The address and telephone number are:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

The PCP applicant will receive the standard DMAS Participation Agreement with a listing of the MEDALLION Provider Requirements (Appendix A) and the MEDALLION Provider Enrollment Form. (See "Exhibits" at the end of this supplement for samples of these documents.) In completing the Participation Agreement, the physician must check the box indicating his or her desire to be a MEDALLION PCP and stipulate to the PCP requirements of Appendix A. In addition, the MEDALLION Provider Enrollment Form asks the physician to specify the maximum number of MEDALLION patients that he or she can accommodate in his or her practice. This is the physician's "panel," and it is limited to a maximum of 1,500 MEDALLION patients. The PCP is also asked to state whether he or she is fluent in any language other than English and to identify any specialties or subspecialties in which the practitioner is qualified. By agreeing to participate in the MEDALLION program and providing the services described subsequently in this section, the PCP will be paid a $3.00 monthly case management fee for each MEDALLION patient in his or her panel. PCPs receive a list monthly from DMAS or its contractor which includes new and existing MEDALLION patients assigned to the PCP's practice.

Providers who may enroll to provide MEDALLION services include, but are not limited to, physicians in the following primary care specialties: general practice, family practice, internal medicine, obstetrics and gynecology, and pediatrics. Federally Qualified Health Centers, Rural Health Clinics, and certain Local Health Departments may also serve as primary care providers. In addition, exceptions may include:

- Physicians specializing in obstetric/gynecologic care when selected by a female recipient as her PCP and then only if the physician agrees to provide or refer the female recipient for necessary primary care; or

- Other specialty physicians under extraordinary, recipient-specific circumstances when DMAS determines, with the provider's and recipient's concurrence, that the assignment would be in the recipient's best interests. Such circumstances may include, but are not limited to, the usual-and-customary practice of general medicine by a board-certified specialist to maintain a pre-existing patient/physician relationship, or to support the special medical needs of the recipient.

To serve as a PCP, the provider must:

- Function as the "gatekeeper" and primary care physician for recipients assigned to his or her caseload. Included, but not limited to, are specific responsibilities for:

  - Providing care coordination for health care services including physician services, pharmacy services, hospital inpatient and outpatient services, laboratory services, ambulatory surgical center services, radiological services, home health services, and durable medical equipment and supplies;

  - Making available 24-hour, 7 days per week access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so that information can be given about accessing services or how to handle medical problems during non-office hours. The PCP must also maintain reasonable and adequate office hours for assigned patients and must not discriminate against those patients with regard to office hours available;

  - Determining the need for and authorizing when appropriate, all non-emergency care;

  - Providing EPSDT (Early and Periodic Screening, Diagnosis and Treatment) services or have referral arrangements with another qualified health care professional to provide these services for children under the age of 21 in accordance with DMAS guidelines (see the EPSDT section of the *Physician Manual*);

  - Making referrals when appropriate, conforming to standard medical practices, to medical specialists or services. The referral duration will be at the discretion of the provider, and must be fully documented in the patient's medical record. MEDALLION makes available an optional referral form (see “Exhibits” at the end of this chapter for a sample);

  - Coordinating inpatient admissions either by personally ordering the admission or referring to a specialist who may order the admission. Prior authorization is required for all inpatient admissions, except in an emergency. The PCP must directly refer all non-emergency admissions. Prior authorization is conducted by a DMAS contractor (see the DMAS *Physician Manual* for additional information);

  - Maintaining a legibly-written, comprehensive, unified patient medical record for each recipient;

  - Documenting in each recipient's record all authorizations for referred services;

- Providing education and guidance to enrolled recipients to teach them how to access medical care and promote good health practice;
- Tracking and documenting any emergency care provided to recipients;
- Preparing BabyCare risk screens for pregnant females and high-risk children under age two and refer and coordinate with BabyCare provider (see the BabyCare risk screen forms in "Exhibits");
- Enrolling in the free Virginia's Vaccine for Children Program (VFC); and
- Referring to associated programs, e.g., Early Intervention Services and Women, Infants, and Children's Supplemental Food Program (WIC).

Providers must have admitting privileges at a local accredited hospital or must make arrangements for admissions with a physician who does have admitting privileges. To indicate that the inpatient admission or outpatient services were authorized, the hospital provider must enter the seven-digit Medicaid identification number of the PCP in Locator 83A (Other Physician ID) on the UB-92 billing invoice. If the attending physician is the PCP, enter his or her seven-digit provider number in Locator 82 (Attending Physician I.D.).

NOTE: All existing DMAS requirements and regulations regarding utilization pre-authorization and service allowances remain in effect. That is, the MEDALLION PCP authorization does not override existing service limitations, and is required for payment for allowed services provided to MEDALLION recipients.

DMAS reviews applications from physicians and other health care professionals to determine the appropriateness of their participating as a MEDALLION PCP. DMAS may also review recipient requests for choosing a specific PCP for appropriateness and to ensure recipient accessibility to all required medical services.

Providers who fail to fulfill the above requirements may be subject to the following actions, which include sanctions for violation, breach, or nonperformance of provider agreement terms as provided for in 12VAC30-120-350:

- **Informal Counseling or Inquiry -** A review of the provider's procedures and policies to clarify any uncertainties or to inquire into the circumstances of an incident. Usually conducted by telephone.
- **Letter of Sanction -** Formal correspondence informing the provider of a breech of regulations or nonfulfillment of a requirement. Usually preceded by an informal investigation into the circumstances.
- **Suspension** of new enrollment and/or disenrollment of existing recipients.
- **Temporary suspension** – Withhold all or part of case management fees.

- **Termination** of the provider from MEDALLION. Termination from MEDALLION does not mean termination from Medicaid.

- **Termination** of the provider from Medicaid.

SECTION IV
RECIPIENT ELIGIBILITY

MEDALLION recipients within the targeted geographic areas will be Medicaid-eligible or Children's Medical Security Insurance Program (CMSIP) individuals in the following categories:

- Family and children-related groups; and

- Non-institutionalized persons who are aged, blind, and disabled.

Medicaid recipients within the targeted geographic areas will be excluded from participating in MEDALLION if they:

- Receive a Home and Community-Based Care Waiver service offered as an alternative to institutional care to elderly and disabled persons, persons with mental retardation, persons with AIDS/HIV, and technology-assisted children (i.e., personal care, respite care, adult day health care, private duty nursing services, and intensive assisted living);

- Reside in mental hospitals and ICF/MR facilities;

- Reside in nursing facilities;

- Are eligible for foster care or under subsidized adoption programs;

- Live outside of the area of residence for more than 60 days except when placed to receive medically necessary services;

- Have an eligibility period that is only retroactive;

- Are receiving hospice services;

- Are receiving Client Medical Management Services;

- Are in spend-down cases;

- Are refugees; or

- Have Medicare or any other comprehensive group or individual insurance.

An individual may be excluded from participating in MEDALLION if the recipient is enrolled in the caseload of an assigned PCP whose enrollment has been canceled and other PCPs have declined to enroll him or her.

Recipient Enrollment Process

Once determined eligible for Medicaid, recipients receive an interim Medicaid card and are authorized to receive medical care in accordance with Medicaid current procedures. These newly eligible individuals do not participate in MEDALLION until they are notified by DMAS that they are eligible for the program.

Within 45 days, the recipient receives a letter and a list of Primary Care Providers in his or her locality. The letter names a proposed PCP and offers the recipient the option of selecting a PCP of his or her choice from the list if the physician named in the letter is unacceptable. Recipients must notify DMAS of the new PCP as of the date stated in the letter. If DMAS does not receive notification by this date, the recipient's PCP will be the physician named in the letter. With the selection of a Primary Care Provider, the individuals are enrolled as MEDALLION recipients and receive unique MEDALLION identification cards to replace the Medicaid cards.

Mandatory Assignment of a PCP

Assignments are made for those recipients not selecting a PCP as described above. The assignment process is as follows:

- Automated assignments of a Primary Care Provider (PCP) in the MEDALLION program is based on one of three criteria: previous assignment to a PCP, past claim history with a PCP, or random assignment to a PCP when no previous or historical association exists. Whether the assignment is by previous assignment, claim history, or random criteria, an effort is made to keep family/cases together. If, however, that primary care provider has a closed panel, the beneficiary is assigned, on a randomized basis, to the nearest primary care provider. In assigning pediatricians and OB/GYNs, the algorithm considers previous source of care and family source of care when possible, as well as age and sex.

- Each provider is assigned a recipient, or family group if appropriate, in turn until the maximum number of recipients the provider has elected to serve has been reached, until there are no more recipients suitable for assignment to that provider or all recipients have been assigned.

- In localities where *Options* is available, recipients not selecting a PCP are instead assigned to an *Options* HMO. Continued enrollment in the HMO, however, is voluntary.

Changing of a Provider

MEDALLION recipients have the initial 90 calendar days following the effective date of enrollment with a MEDALLION PCP to change PCPs. After the initial 90-day assignment period, the recipient shall remain with the PCP for the remainder of a 12-month period. After that time, recipients may elect to change PCPs. Changes may be made annually thereafter.

Requests for a change of PCP "for cause" are not subject to the annual limitation, but are

reviewed and granted by DMAS staff on an individual basis. Examples of changing providers "for cause" may include, but are not limited to:

- The recipient has a special medical need which cannot be met in his or her service area;
- The recipient has a pre-existing relationship with a MEDALLION provider rendering care for a special medical need;
- Both the recipient and the provider reach a mutual decision to sever the relationship;
- The provider or recipient moves to a new location or residence causing transportation difficulties for the recipient; or
- The provider cannot establish a rapport with the recipient.

The current PCP retains the recipient in the caseload and provides services to the recipient until a new PCP is assigned or selected. If the PCP is terminating the relationship for good cause, written notice must be sent to the recipient and DMAS. The PCP must provide continuous coverage for the recipient for up to 45 days until a new PCP is assigned or selected.

MEDALLION Identification Card

Each enrolled recipient receives a MEDALLION card, which is distinct from the Medicaid card in appearance and contains the MEDALLION logo.

The front of the card includes the recipient's name, Medicaid case identification number, birth date, sex, PCP's name, address, 24-hour access number, and the effective and ending dates of the card.

The reverse side of the card contains the following statements:

- "Members: Carry this card with you at all times and present it whenever you receive medical care. All non-emergency care must be under the supervision of your Primary Care Provider. Except in emergencies, you must contact your Primary Care Provider listed."
- "Providers: This card is for identification purposes only, and does not guarantee coverage. All non-emergency services must be approved by the Primary Care Provider listed."

The 24-hour access telephone number for the recipient's PCP and the Managed Care Helpline Hotline number (1-800-643-2273) are listed on the card.

Recipients contact their PCP or designated covering physician to obtain authorization prior to seeking non-emergency care. **Emergency services are provided without delay or prior authorization.** However, the physician providing treatment must document the

nature of the emergency and must report it to the PCP after treatment is provided. Recipients must inform the PCP of any emergency treatment received.

See "Exhibits" at the end of this supplement for a sample MEDALLION identification card.

SECTION V
COVERED SERVICES AND LIMITATIONS

Services to be provided by or through a referral from the PCP include, but are not limited to, the following:

- Routine preventive and treatment services provided by the PCP;
- Inpatient and outpatient hospital non-emergency admissions and services or referral and authorization for services;
- Referral and authorization for appropriate specialty services required for diagnosis and treatment;
- Arrangement for ancillary services for diagnosis and treatment; and
- Patient education to promote good health practices and the appropriate use of medical resources.

The following services are exempt from the referral requirements of MEDALLION:

- Dental services (provided only to persons under 21)
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) and immunization services provided through local health departments;
- School-based services;
- Emergency room services;
- Psychiatric/psychological services (limited sessions of outpatient treatment);
- Obstetrical and gynecological services;
- Family planning services;
- Routine newborn services;
- Targeted case management services which assist an eligible individual to gain access to needed medical, social, educational, and other services;
- Services to treat Sexually Transmitted Diseases;

- Transportation services (except in localities included in the pilot preauthorization program);
- Annual or routine vision examinations (under age 21);
- MH/MR community rehabilitative services; and
- Pharmacy services.

While reimbursement for these services does not require a referral from the PCP, the PCP must track and document them to ensure the continuity of care.

SECTION VI
PROVIDER REIMBURSEMENT AND BILLING INSTRUCTIONS

DMAS pays for services rendered to MEDALLION recipients through the existing fee-for-service methodology and a $3 per member per month management fee.

PCP providers bill for services on the Health Insurance Claim Form, HCFA-1500 (12-90). Complete the invoice and submit it according to the instructions provided in Chapter V of the Medicaid *Physician Manual*. See "Exhibits" at the end of this Supplement for a sample of the Health Insurance Claim Form, HCFA-1500 (12-90).

To receive payment for their services, referral providers authorized by a recipient's PCP to provide treatment to that recipient must place the Medicaid Provider Identification Number of the PCP in Locator 17a (I.D. Number of Referring Physician) of the billing invoice. Subsequent referrals resulting from the PCP's initial referral will also require the PCP's Medicaid provider number in this block.

SECTION VII
UTILIZATION REVIEW

DMAS reviews claims for services provided by or resulting from referrals by authorized PCPs. Claims are reviewed for the following and may be reviewed for additional elements:

- Excessive or inappropriate services (e.g., prescription drugs or emergency room visits);
- Unauthorized or excluded services; and
- An analysis of possible trends in the increase or reduction of services.

These utilization review elements are in addition to the Utilization Review requirements identified in the provider manuals for individual providers and services.

SECTION VIII
RECIPIENT AND PROVIDER APPEALS

Any denial of a service decision made by DMAS staff may be appealed to the Department

of Medical Assistance Services. See the recipient and provider appeals information in the provider manual. This decision must be appealed in writing by the recipient or his or her legally appointed representative. All appeals must be filed within 30 days of the date of the final notification. Applicant/recipient appeals should be directed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Providers may submit appeals to DMAS on an individual basis. Appeals must be made in writing and must include all supporting documentation related to the appeal. MEDALLION providers may appeal actions including, but not limited to, the following:

- Case management payments;
- Recipient assignments to the PCP caseload;
- Imposed sanctions; and
- Eligibility to enroll as a PCP.

The following procedures are available to all providers when DMAS takes adverse action listed above or which includes termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 15 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

EXHIBITS

EXHIBITS TABLE OF CONTENTS

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program
Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____

Check this box if requesting new number→ ☐

☐ If you wish to be a MEDALLION PCP, check this box. The MEDALLION provider enrollment form must be attached.
☐ If you are already a MEDALLION provider, check this box.

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
INDIVIDUAL PROVIDER NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
6. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **If qualified to be a Primary Care Provider, the applicant agrees to comply with all applicable MEDALLION state and federal laws, administrative policies and procedures of DMAS, and the requirements identified in Appendix A as from time to time amended.**
12. **This agreement shall commence on _____ and terminate on _____.**

For First Health's use *only*

Director, Division of Program Operations Date

For Provider of Services:

Original Signature of Provider **Date**

Provider Specialty

_____City OR _____County of _____

Board License Number **(Area Code) Telephone Number**

IRS Identification Number (Required) **UPIN**

Medicare Carrier and Vendor Number

IRS Identification Name (Required)
mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit**
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

APPENDIX A
MEDALLION PROVIDER REQUIREMENTS

Medicaid enrolled physicians with a specialty of obstetrics/gynecology, general/family practice, pediatrics, internal medicine, or other specialties approved by the Department of Medical Assistance Services. Qualified Health Department Clinics, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) may be MEDALLION primary care providers (PCP). The MEDALLION PCP agrees to the following:

1. Function in the role of PCP for MEDALLION. In this role, the Provider will carry out all routine preventative and treatment services to MEDALLION patients assigned to the PCP's practice. The PCP will carry out Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services **or** have referral arrangements with another qualified health care professional and will maintain a comprehensive medical record for each patient assigned to the PCP's MEDALLION panel. In particular, the PCP will provide and/or coordinate patient management for all preventive, primary, and specialty health care services. The PCP must have admitting privileges at a local accredited hospital or must make arrangements for admissions with a physician who does have admitting privileges.

2. Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours. Maintain reasonable and adequate office hours for assigned patients, and not discriminate against those patients in regards to office hours available.

3. Coordinate all other Medicaid authorized care for each patient enrolled in his or her MEDALLION caseload including referral to specialty providers for medically necessary services. In referring for specialized evaluation and/or treatment, the PCP will provide the specialist with authorization to cover appropriate testing and treatment. This authorization may be verbal or written for a period appropriate to the illness. The PCP will document all referrals in the patient's medical record.

4. The PCP will not restrict patient access to services exempt from MEDALLION referral requirements as specified by DMAS as exempted services which includes family planning, emergency services, obstetrical, and gynecological services.

5. Complete a BabyCare risk screen on every MEDALLION patient assigned to the PCP's panel who is eligible to receive a risk screen. If the patient is determined to be at risk and eligible to receive BabyCare services, the PCP must either provide BabyCare services (if the PCP is an enrolled BabyCare Provider) or refer the eligible patient to a Medicaid enrolled BabyCare Provider.

6. Enroll and participate in the Commonwealth of Virginia's Vaccines for Children (VFC) Program.

7. Provide case management, primary care and health education to enrollees that fosters continuity of care and improved provider/patient relationships.

8. Not refuse an assignment or disenroll a patient or otherwise discriminate against a patient solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider.

9. The PCP may request reassignment of a MEDALLION patient to another PCP, if the patient/PCP relationship is not mutually acceptable, patient's condition or illness would be better treated by another PCP or other reasons approved by DMAS. The PCP must notify the patient in a direct and timely manner of the PCP's desire to remove the patient from their caseload and keep the patient in the PCP's panel until another PCP is assigned or until the patient has been disenrolled from MEDALLION.

10. Providers will receive the usual Medicaid fees for services rendered (physician will also receive a monthly case management fee for each client assigned). See the MEDALLION supplement of the Medicaid Physician manual for specific billing instructions.

11. The PCP's Medicaid Provider Number will be used as the MEDALLION identification number.

12. In the event, the PCP fails to comply with these provisions, appropriate sanctions, up to and including termination from participation as a MEDALLION PCP, will be applied by DMAS. See paragraph (10) of the Medicaid Participation Agreement with respect to appeals, and the MEDALLION supplement to the Physician's Provider Manual with respect to sanctions.

13. The requirements outlined in this appendix will expire concurrent with any termination or expiration of the Provider Participation Agreement. However, these requirements may be terminated for any reason on thirty (30) days notice by either party without mandatory termination of the Agreement.

PLEASE KEEP FOR YOUR RECORDS!

MEDALLION PROVIDER ENROLLMENT FORM

PLEASE TYPE or PRINT: ***Sections I and II must be completed for this form to be valid.***

Note: **Physicians with a specialty of obstetrics/gynecology, pediatrics, general/family practice, or internal medicine; health department clinics, FQHC's and RHC's may be MEDALLION PROVIDERS.**

SECTION I: General Information *(Mandatory)*

Provider Name: _____ **Provider Number:** _____

Practice Name: _____ IRS ID number _____

Street Address: _____ Contact Person: _____

Telephone Numbers: _____ Contact Phone: _____

24-hour Access: (Required) _____ Email: _____

Office: _____ FAX: _____

(This address and 24-hour access telephone number will print on the client's MEDALLION card. The address *must* be a physical street address.)

SECTION II: MEDALLION Panel Information *(Mandatory)*

Panel Enrollment Size: (enter a value between 1 and 2000)

Initial Case load: _____ (2000 client maximum per physician)

Patient Type: (Indicate with a check mark and **select only one**)

- ☐ Adults and Children*
- ☐ Adults only*

Is your practice wheelchair accessible?

- ☐ Yes
- ☐ No

Is your practice multilingual? If so, please check language(s).

- ☐ Spanish
- ☐ Korean
- ☐ Vietnamese
- ☐ Other _____

_____

Panel Enrollment Type: (select only one)

- ☐ Open (History & Random) Practice will accept all MEDALLION patients not to exceed panel enrollment size.
- ☐ History Only (only patients billed to Medicaid within the last 12 months will be assigned to your panel. No other patients can be added unless your office contacts the MEDALLION Unit directly by phone, or by FAX with the Client Assignment Fax form.)
- ☐ Existing Patients Only (only the patients that you have listed will be assigned to your panel. Note: You must provide the MEDALLION Unit with a list of patients with Medicaid numbers. No other patients can be added unless your office contacts the MEDALLION Unit directly by phone (800-643-2273) or by FAX (800-613-5955) with the Client Assignment Fax form.

Please note: Our system is not devised to stipulate specific age limits. Therefore, providers may only be enrolled to either accept children or to exclude them entirely. "Children" are recipients under the age of 19. (Example: I f your practice is exclusively adolescent medical care only, then you would need to choose an "Existing Clients Only" type of panel.)

SECTION III: Service Locations *(Optional)*

Please list all Medicaid provider identification numbers issued to you.

Medicaid Number	Medicaid Number
_____	_____
_____	_____
_____	_____

SECTION IV: Affiliations *(Optional)*

Your associated physicians in the practice can be affiliated for business and billing purposes. If you wish to affiliate physicians within your practice location, please list the names and Medicaid numbers of those physicians in the practice location:

Physician Name	Medicaid Number
_____	_____
_____	_____
_____	_____
_____	_____

INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health.

The risk screen is designed to capture high risk infants as identified by the BabyCare Program. *Risks must not be altered.* Please check all risks that apply to the recipient and make the appropriate referral.

PATIENT NAME: _____ VMAP ID#: _____

PARENT/GUADRDIAN NAME: _____

PATIENT ADDRESS: _____ PHONE #: _____

A. MEDICAL

- ☐ Diagnosed developmentally delayed/neurologically impaired
- ☐ Diagnosed medically significant genetic condition (including sickle cell disease)
- ☐ Birth weight 1750 grams (3 lbs., 14 oz.), or less
- ☐ Chronic illness
- ☐ Diagnosed with fetal alcohol syndrome (FAS)
- ☐ Medical high rise infant and pediatric care needed, but not available 24 hours a day
- ☐ Medical condition(s) the severity of which requires care coordination (document medical condition below)
- ☐ Born exposed to an illegal drug
- ☐ Failure to thrive or flattening of growth curve

B. SOCIAL

- ☐ Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)
- ☐ Maternal absence (illness, incarceration abandonment)
- ☐ Parental substance abuse/addiction (only includes father if living in home)
- ☐ Caregiver's handicap presents risk to infant (physically impaired, hearing impaired, vision impaired)
- ☐ Caregiver mental illness/mental retardation
- ☐ Shelter, homeless or migrant worker
- ☐ Mother 18 years or younger
- ☐ History of suspected abuse/or neglect
- ☐ Non compliant with follow-up visits/screening visits and medical direction for this infant

C. NUTRITION

- ☐ Congenital abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification
- ☐ Inadequate diet

REFERRAL: ☐ Care Coordination

☐ No Care Coordination – What services will the recipient receive? _____

PROVIDER COMMENTS, SUGGESTION, OR INSTRUCTIONS: _____

_____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER ID # _____

REV. 8/99 J:\TRAINING\BABYCARE\DMAS-17

REFERRAL TO HIGH-RISK CARE COORDINATION

PRIMARY CARE PROVIDER REFERRAL FORM

Instructions for Use: *This referral is valid only if authorized by the MEDALLION[SM] client's Primary Care Provider (listed on the MEDALLION[SM] I.D. card), and is valid only for the services and durations specified. Should additional referrals be necessary, the referral must be authorized by the Primary Care Provider. Please provide the Primary Care Provider with full documentation of diagnosis/ treatment and/or therapies ordered.*

Name of MEDALLION[SM] Patient: _____

MEDALLION[SM] I.D. # _____

Today's Date: _____

REFERRED TO: _____

Reason for Referral:

_____

_____

Number of Visits Authorized: _____

Time Frame of Authorization: _____

_____ _____

Signature of Primary Care Provider | MEDALLION[SM] I.D. Number

_____ _____

Printed Name of Primary Care Provider | Telephone Number

_____

_____

Address

DUPLEX PRODUCTS ▲ 692943F

CASE I.D. NUMBER PLUS	BIRTH DATE	SEX	I.D. NO.	SI	NAME	BEGIN DATE

THE FOLLOWING INDIVIDUAL IS ELIGIBLE THROUGH THE LAST DAY OF →

THE FOLLOWING INDIVIDUAL IS ELIGIBLE FROM ▼

MEDALLION℠ ELIGIBILITY CARD

DETACH THIS CARD AT PERFORATION BELOW. FOLD INTO THREE SECTIONS, AND KEEP WITH YOU AT ALL TIMES.

INSTRUCTIONS ON BACK

INSURANCE INFORMATION CD= C/C=

CASE I.D. NUMBER PLUS	CARRIER	BEGIN DATE	I.D. NO.	TYP	POLICY NO. / MEDICARE NO.

V O I D

FOLD

▼ DETACH HERE BEFORE USING CARD ▼

NOTICE TO CLIENT: (PLEASE READ BEFORE USING THE ATTACHED CARD ABOVE)

FOLD

FOLD

INSTRUCTIONS TO RECIPIENTS

1. This is your Medicaid card which shows who in your family is eligible for Medicaid services. It is issued by the Department of Medical Assistance Services.
2. Only those persons listed on the card are entitled to Medicaid services.
3. Show this card to the hospital, doctor, drug store and any other medical service provider every time you receive a medical service. You may also have to show some identification.
4. If you do not show this card to providers of care when you receive medical services, you may have to pay for the services.
5. The medical service provider must currently be enrolled with the Virginia Department of Medical Assistance Services. Ask the provider before you receive a service if he or she is enrolled with Medicaid.
6. This card is good only for the dates shown on it.
7. Call your local Department of Social Services immediately if you change your address, if your income or resources change, if your health insurance changes, or if you lose your Medicaid card.
8. If you have any questions about your medical benefits, call your local Department of Social Services.
9. **WARNING:** Intentional misuse of this card is against the law, is fraud, and will make the offender liable to prosecution under federal and state laws.

FOLD

SPECIAL INDICATOR CODES

A = Under 21, no co-pay, eligible for certain additional services.
B = No co-pay required on any service.
C = Certain co-pays apply.

NOTE: No co-pays apply for:

- Any pregnancy-related service, drug or supply
- Any family-planning service, drug or supply
- Any service delivered in an emergency room
- Any service defined by Medicaid as an emergency service

INSTRUCTIONS TO PROVIDERS OF SERVICE

1. Be sure to see the card each time service is provided.
2. Another form of identification may be requested to verify the recipient's identification.
3. This card is valid for the dates indicated.
4. Only those persons listed on this card are eligible for benefits.
5. A provider must be currently enrolled with the Department of Medical Assistance Services Program to receive payment.
6. If there are primary care providers indicated on the face of this card, other providers should not render services except on an emergency basis or upon referral from the designated primary care providers.
7. If there are questions, contact the Department of Medical Assistance Services, P.O. Box 537, Richmond, Virginia 23204.

FOLD

FOLD

FOLD

TO OPEN - TEAR ALONG PERFORATION

FOLD

FOLD

TO OPEN - TEAR ALONG PERFORATION

FOLD

0000037

DO NOT FORWARD

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
POST OFFICE BOX 26228, RICHMOND, VIRGINIA 23260

FIRST CLASS MAIL
U.S. POSTAGE
PAID
PERMIT NO. 176
RICHMOND, VA.

L

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500